**PSYCHIATRIC SECURITY REVIEW BOARD**

**Psychiatric Security Review Board (PSRB) Training**

2021 TRAINING ENROLLMENT REGISTRATION FORM

# PLEASE PRINT CLEARLY OR TYPE – APPLICATIONS MUST BE LEGIBLE TO BE PROCESSED.

**Training will be held virtually via Microsoft Teams, 9-11:30 a.m. until otherwise noted**

***PLEASE CIRCLE ONE DATE:***

**February 4, 2021 March 2, 2021 March 23, 2021 June 3, 2021 August 5, 2021**

**October 7, 2021 December 2, 2021**

***Check One:*** \_\_\_\_DMHAS State Employee \_\_\_\_State Employee (Non DMHAS) \_\_\_\_DMHAS Funded Agency Employee

\_\_\_\_Other *(please explain)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Last Name First Name Middle Initial***

Job Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Name/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Tel: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Fax: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(REQUIRED)**

***Check One:***

\_\_\_\_ I am currently providing treatment or supervision to a PSRB acquittee in the community.

\_\_\_\_ I anticipate providing treatment or supervision to a PSRB acquittee in the community within the next year.

\_\_\_\_This training is not mandatory for me but I am interested in learning about the PSRB.

***Please Circle:***

*Certification/Licensure* *Highest Degree*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| APRN | CADC | LMFT | LADC | OTHER | AA | AS | BA | BS | BSN | BSW | MA | MS | OTHER |
| LPN | RN | LCSW | LPC |  | MSN | MBA | MFT | MSW | MD | PSYD | PHD |  |  |

Please indicate any special accommodations needed for disabilities governed by the Americans with Disabilities ACT (ADA):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUPERVISOR’S APPROVAL

I approve this employee’s request to register for this training event and authorize the employee to attend:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Printed)* *(Signature)* (*Date)*

Fax registration forms to 860-566-1425 at least 7 days prior to your training date.

Invitation will be sent via email one week prior to training. Notification will be sent if training is full.

Mailing address: PSRB, 505 Hudson Street, 1st floor, Hartford CT 06106 Tel: 860-566-1441